

Providence Hospital Summer Internship Program in Biomedical Research

Program Overview

The Volunteer Summer Internship program, in the Patient Care Research Department at Providence Hospital, offers students, who are high school seniors, college undergraduates or medical students, the opportunity to learn biomedical research methods in a hospital laboratory setting. Four students will be enrolled full-time, on a volunteer basis, in one of two 8-week sessions, each summer.

Prior to starting, Volunteer Services requires each new intern to go through the Providence Hospital Orientation and to submit a physician's statement affirming a negative TB test (conducted free of charge at our facility, if necessary). Students will be expected to abide with corporate guidelines for attendance, conduct and dress.

Students may be selected to assist with graduate medical research projects as assigned by a Research Associate. Research techniques may include cell culture, biochemical assays, PCR, western blot, etc. Interns may also be asked to perform data entry, literature searches, and general laboratory upkeep, in addition to their research responsibilities. Because Interns may be required to work with potential biological and chemical hazards, they are required to abide by safety rules and guidelines.

Submission Deadline: February 28, 2007

Please submit application to:

David M. Svinarich, Ph.D.
Director, Patient Care Research Department
Attn: Summer Internship Program
Department of Research
16001 West Nine Mile Road
Southfield, MI 48075

Notification Date: April 2, 2007

Students accepted for the program will be notified by mail

Please circle sessions for which you are available:

Session I: May 1- June 29

Session II: July 2- August 31

Application for Volunteer Summer Internship 2007

Name: _____

(First Name, Middle Initial, Last Name)

Address: _____

(Number, Street, City, State, and Zip Code)

Cell Phone: _____

Phone: _____

E-mail: _____

Parent/Guardian: _____

Address _____

(Number, Street, City, State, and Zip Code)

Cell Phone: _____

Home Phone: _____

E-mail: _____

Hospital Affiliation: Do you have a relative employed at Providence Hospital?

Name: _____

(First Name, Last Name, If a physician please indicate MD)

Relationship: _____

Academic Level: Check highest level completed at time of application

High School: Junior Senior

University: Freshman Sophomore Junior Senior

Major:

Medical Students: Year 1 Year 2 Year 3 Year 4

Relevant Experience: _____

Science courses: _____

Lab courses: _____

Research experience, if any: _____

**Have you participated in the Providence Hospital Research Department
Summer Internship Program before?**

No **Yes, When?** _____

Please describe your career/academic objectives.

Please explain why you would like to participate in the internship program.

Questions? Please contact Dr. Svinarich

Telephone: 248-849-3997

E-mail: david.svinarich@providence-hospital.org